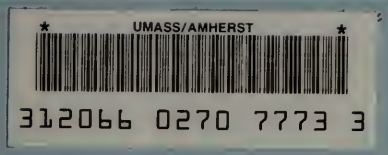
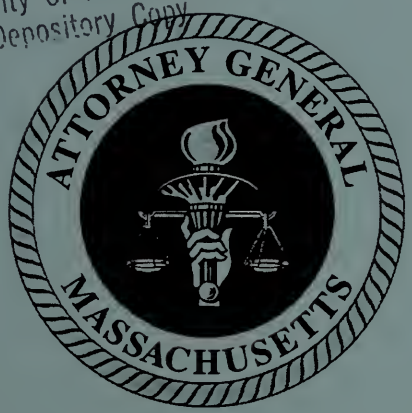


THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS



January, 2000

TOM REILLY
ATTORNEY GENERAL
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TOM REILLY
ATTORNEY GENERAL

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January 2000

Dear friends and colleagues:

As we near the fifth anniversary of the Community Benefits Guidelines, I am proud to support this important initiative.

Every nonprofit acute care hospital in the Commonwealth participates in this program. With the encouragement of the Massachusetts Hospital Association and with the dedication of numerous health care advocates and community partners, our initiative has achieved national recognition. This status was achieved not through government regulation or legislative mandate, but by a public-private sector partnership guided by voluntary cooperation among the participants.

Changes in health care delivery have been significant since 1994 when the Attorney General's Guidelines were first issued. Over the past few years, managed care has played a more significant role in the health care system in Massachusetts, with its emphasis on cost-effective treatment. Hospital revenues have declined as fewer patients are hospitalized, hospital stays are shorter and federal funding has been cut. Some community hospitals have closed their doors.

In this changed environment, I believe that the Guidelines still perform a valuable role.

- The Guidelines foster community dialogue, institutional collaboration, and methodical planning--all the more necessary in an era of tight budgets.
- The Guidelines focus on the need for affordable programs for disadvantaged populations.
- The Guidelines, along with the Community Benefits Advisory Task Force, have created the environment for an impressive public-private partnership.

As we continue with the important work embodied in the Community Benefits Guidelines, I want to thank all those who have enriched this initiative with their interest and support.

Sincerely,

Tom Reilly

EXECUTIVE SUMMARY: ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS

Thank you for your interest in the Attorney General's Community Benefits Guidelines. It is our hope that Massachusetts nonprofit acute care hospitals, working with their communities, will begin to adopt and implement these voluntary Guidelines. For those which may have already begun to implement other community benefits guidelines, including but not limited to those of the Kellogg Foundation, the Catholic Health Association, and the Voluntary Hospitals of America, these Guidelines are sufficiently flexible to enable hospitals to adapt such on-going processes to fit these Guidelines.

The Attorney General wishes to extend his personal appreciation to everyone who provided assistance to this office during the development and refinement of these Guidelines. The many thoughtful comments and suggestions have been carefully considered and, where consistent with the goals of our initiative, have been incorporated into the final draft.

We continue to welcome feedback from hospital trustees, administrators, health care advocates, community representatives, and others, as the Guidelines are put into practice. Future editions of the Guidelines will benefit from your continued assistance and constructive criticism.

Attorney General Perspective

As you are aware, one of the Attorney General's priorities has been to use the law enforcement and statutory oversight powers of this office to address a broad range of health care cases and policy issues. This is because the impact of the problems generated by an inefficient and inequitable health care system are felt virtually everywhere in this office, including the areas of consumer protection, public charities, insurance, antitrust, and Medicaid fraud control. On the basis of our experience, we believe that many populations — the working poor, the elderly, at-risk women and children, and others who are without adequate health insurance or access to health care now — may continue to lack elementary primary and preventive medical care even with national or state health care reform.

Based on our casework and issues that are brought to our attention by the public, we are concerned that a more competitive and cost conscious health care system, one that is evolving and changing rapidly, may prompt some nonprofit acute care hospitals to curtail or eliminate services needed by disadvantaged patient populations, or to simply grow apart from their communities. Thus, we have developed these voluntary Guidelines in an effort to create a level playing field with respect to the expectation that all such hospitals will make or continue to make community benefits an integral part of their institutional missions.

Although these Guidelines are intended for use by hospital providers, we expect to work with other nonprofit institutions, such as health maintenance organizations, to adapt these Guidelines to serve their charitable purposes as well.

Approach Taken in the Guidelines

As you will note, we have retained the general approach of our earlier draft. The governing board of each nonprofit acute care hospital, in partnership with its community, is asked to identify that community's health care needs and to develop and implement a responsive coordinated plan. The specific details of how the hospital defines its community and develops its plan are left to the discretion of the institution, within the broad parameters described by the Guidelines. Each hospital is then requested to report to this office on an annual basis the status of its plan, including resources committed and benefits provided.

While the general approach of the earlier draft is retained, numerous modifications and clarifications were made in response to comments and suggestions. For example, in areas of special concern to those who commented, refinements were made as explained below:

Standards of Accountability (Part IV (F) (3))

This section of the Guidelines received the most attention and was clearly the most controversial. On the one hand, some hospital representatives warned that any quantitative attempt to measure community benefits expenditures would prove counter-productive, distracting attention from the task of providing necessary health care services. The Attorney General was urged to eliminate any suggestion that hospitals quantify community benefits and to adopt instead one of the hospital-generated community benefit standards, such as the Kellogg Program, that do not include suggested spending levels or principles of quantification. Some commenters argued that the inclusion of suggested benchmarks would give some community groups "leverage" to extract unreasonable demands from financially strapped hospitals. Others asserted that if hospitals devoted resources to community benefits programs, it would result in job losses and financial hardship.

On the other hand, some community health care advocates and public health analysts, inspired by recent state legislation enacted or pending in other jurisdictions, requiring minimum levels of hospital charity care expenditure, urged the Attorney General to turn the Guidelines into regulations. Many also expressed concern that, in the absence of regulations, hospitals would make merely formal gestures of compliance. Some commenters recommended that the benchmarks be increased, while others argued that the "reasonable amount" standard be dropped entirely and that hospitals be given only the option of a benchmark percentage.

In addition, some advocates argued that the Guidelines should, in general, be less flexible and more prescriptive and that only a narrow category of health care services be eligible to be counted as community benefits in arriving at a target benchmark. Further, some community representation advocated that only true uncompensated charity care be counted as a community benefit, and that hospitals not be allowed to use donated funds, grants, or any research funds in the measurement of community benefits.

A few commenters, rejecting extreme positions by some hospitals and community advocates, urged that the Attorney General consider deferring recommended benchmarks until at least one cycle of community benefits data could be reported in accordance with the remainder of the Guidelines. These commenters, who acknowledged the desirability of quantification, argued in favor of collecting community benefit spending levels from all hospitals before final recommendations on

any target levels are made.

We reviewed all the comments which we received and met on several occasions with both hospital and community representatives over the issue of accountability by objective standards. We tried to reconcile what appeared to be the polar positions of some of the advocates and some of the hospital representatives. We pointed out that for providers, the pressures to consolidate, to eliminate excess capacity and drive down costs are taking place with or without these Guidelines. Powerful and irresistible forces are at work to make our health care system more economical. Our Guidelines seek to ensure that as we move toward a leaner system, the unserved and underserved health care needs of vulnerable and disadvantaged populations are not overlooked and neglected.

We also recognize that each hospital must have the flexibility to adapt to a changing health care marketplace and implement a community benefits program that best fits its particular circumstances and community. Rigid and inflexible regulation would be counterproductive toward achieving that objective. At this stage in the development of these Guidelines, we have made decisions on the issue of objective measurements consistent with our best assessment of what is reasonable, fair and consistent with our goals to promote and encourage the adoption of community benefits programs in a way that facilitates accountability, ease of monitoring, and credibility in the process.

In furtherance of these goals, but still attentive to the concerns expressed by the commenters, we made the following modifications to the language and concepts in this Section of the Guidelines. First, the order of the standards of accountability was re-arranged so that the reasonable-amount standard, which had been in last position, was placed first. This change was made not only because it appeared that several commenters had either overlooked or had not been aware of this option, but also because we want to emphasize that it <u>is</u> an option, and a very flexible one, that hospitals and communities should actively embrace.

We also added specific language recommending that the hospital's expenditure level and its reasonableness be determined in collaboration with the community to be served. This is a deliberate attempt to prompt hospitals to consult and cooperate more actively with community groups and representatives in establishing a Community Benefits program.

In our first draft, the second standard of accountability utilized target goals based on total patient operating expenses. With respect to this alternative, while we continue to describe it in the Guidelines, we have deferred recommending this approach for the first two years following the issuance of these Guidelines. We have done so in order to give hospitals an opportunity to implement their stated commitments to work with their communities to develop or expand upon community benefits programs that will meet unserved health care needs and improve community health status.

The deferral is also consistent with the request of many commenters, that this office collect data during the immediate future and make target goal recommendations, if any, after such information has been collected. At the end of two years, we will review the data, and, in consultation with hospitals and community advocates, recommend appropriate adjustments, if any, in this approach.

Although the Guidelines defer recommending this approach, hospitals that wish to consider it, or be better prepared for its possible recommendation at the end of two years, may find the following information useful. The reason for choosing patient operating expenses as a yardstick is to facilitate a comparative review of resources allocated to community benefits programs. While this deferred approach retains the concept of two target levels linked to hospital size, the target percentages themselves would have been adjusted downward from the earlier draft. The range of percentages for hospitals whose total patient operating expenses are under $200 million would have been changed from 2-4% to "up to 3%." For hospitals over $200 million, we would have changed the range, at this point in time, from 4-7% to "3-6%" (page 11).

The changes in the deferred target goals were made to reflect statistical data, not available at the time of the first draft, showing that in fiscal year 1992, most Massachusetts acute care hospitals spent an average of 1.5% of total patient costs on unreimbursed free care alone, an item which is only one of many significant programs that could be counted in the broad measure of community benefits defined in the new draft of the Guidelines.

We have decided to eliminate the third approach, which was to determine community benefits expenditures based on the net value of the hospital's tax-exempt benefit. Our first draft indicated that if this calculation was available, some hospitals and communities would find it a useful measure of the appropriate level of community benefits a hospital should provide. Many hospitals, however, indicated that it was difficult if not impossible to calculate the figure and community advocates were also not in a position to determine the value of the benefit. Some other commenters felt that it signaled some unstated, broader objective to examine the tax exempt status of all types of nonprofit institutions; no such objective exists. Given that it appears that the tax exempt benefits figure is not one which hospitals can readily calculate and given the potential for misunderstanding across a broad range of nonprofit corporations, it made sense to use to delete that approach from the Guidelines. Notwithstanding, however, if there are hospitals that wish to look at this factor, it is still mentioned in the list of factors that a hospital may take into account under the "reasonable amount" approach.

We have added the concept that hospitals should make a "good faith" effort to measure expenditures. Administrative costs associated with the organization of a Community Benefits Plan — which we believe would be nominal — are also a recognized part of Community Benefits expenditures.

The recommendation that hospitals should report the dollar value of both Gross and Net Community Benefits has been retained, (page 9-10), although the measurement of community benefits expenditure levels is based only on the value of Gross Community Benefits (page 11).

In response to several comments received, we have explicitly acknowledged that there are some community benefits that are not easily quantifiable, but they are important and should be reported. Therefore, we have added language which makes it clear that community benefits that cannot be easily quantified, should be described fully and publicly reported (page 10).

Definition of Community Benefits (see Glossary)

We clarified and expanded the definition of Gross Community Benefits to emphasize that it includes health-related community services if such services are incorporated into a formally adopted

plan. For example, domestic violence reduction, education and training services, net financial support of community health centers and community mental health centers, and unfunded programs ancillary to Medicaid or Medicare services, such as certain personal care/home care services for AIDS patients, are just a few of the examples listed in the Glossary (pages 13-14).

We also made it clear that existing community benefits or community services that target the designated community are included within the definition so long as such programs have been incorporated into the Plan (page 13).

In addition, programs developed to comply with regulatory requirements, such as the Determination of Need, may be counted as Gross Community Benefits if such programs have been formalized into a Plan according to the Community Benefits process outlined in the Guidelines. As stated above, those community benefits which cannot be quantified may, nonetheless, be described in the annual report to the Attorney General's Division of Public Charities.

In the Glossary, we have clarified that Net Charity Care means the actual costs, and not the hospital charge, of providing free care to patients (page 13).

Time Frame (Part IV (E)

In response to concerns expressed as to the adequacy of a twelve month period for completion of the community benefits process, the Guidelines have been modified to increase the suggested time for completion to fifteen months. This change was made in recognition of the different relationships that hospitals have with their communities and the differing needs of those communities. While many hospitals in Massachusetts are already providing extensive community based services in response to assessed community needs, others will need more time to develop a productive dialogue with their communities.

Flexibility

In response to comments and concerns that the earlier draft Guidelines appeared to be too prescriptive, the language throughout has been modified so as to make clear that the Guidelines encourage the development of individualized solutions to community health care needs, although hospitals are still encouraged to give priority to the health care needs of unserved and underserved populations within their respective communities.

In addition to the changes explained above, many other modifications have been made in the terms and provisions of the Guidelines. A section-by-section description of those changes is set forth below. Although some of these changes may appear technical in nature, viewed in their entirety, these changes help to make clear the ultimate responsibility of the Board of Trustees and, at the same time, to provide necessary flexibility for trustees and administrators in the development and implementation of a Community Benefits Plan.

The **SCOPE OF THIS DOCUMENT** has been changed to clarify the type of acute care hospitals covered by the Guidelines (page 3). We excluded municipal hospitals because those hospitals, directly supported by tax dollars, by and large already provide needed health care services to disadvantaged populations.

Under **Principle A** (pages 4-5) of the Guidelines, in our recommendation pertaining to the Special Mission Statement, we changed this to emphasize the importance of the hospital-community partnership by asking that the Mission Statement formally affirm the hospital's commitment to the Community (pages 4-5).

Under **Principle B**, in keeping with the ultimate legal responsibility of the hospital governing board, we emphasized that the final decisions regarding the development and implementation of the Community Benefits Plan lie with that board (page 5). We gave recognition to the fact that hospitals differ in management structure by making our recommendations regarding internal planning for Community Benefits more flexible (page 5).

Under **Principle C Section 1 (Defining Community)**, (pages 5-6), the definition of the target patient population has been broadened to embrace all ethnic, cultural, racial, and economic groups, so long as the identification of the tartget patient population is the result of a collaborative hospital-community planning process. In **Principle C Section 2 (Community Process and Input),** (page 6), we eliminated detail in favor of general guidance so as to emphasize the flexibility the Guidelines afford and to recognize the unique situations of certain hospitals. We retained the focus of meeting the needs of unserved and underserved populations and of considering community representatives as partners in the process of identifying health care needs. In order to facilitate coordination of already existing data and expertise, we encouraged the participation of local and state public health departments and other public agencies during any formal needs assessment process (page 6).

Under **Principle D (Needs Assessment and Setting Priorities),** (pages 6-8), we deleted some of the detailed recommendations regarding the Needs Assessment procedure in further recognition of the difference among hospitals and their communities and the fact that a number of hospitals currently are performing needs assessment in their communities. We moved the steps which we suggest be taken in formulating a Community Benefits Plan from Principle B (Overseeing the Development of the Plan) to Principle D (Needs Assessment and Setting Priorities) (pages 6-8).

The language of **Principle F, (Report and Accountability)** has been changed to read as follows: "Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its benefits expenditures and describes the hospital's approach to establishing such expenditures. The hospital should make the Report available to the public." (page 9)

Under **Principle F**, the February 15 deadline for filing the annual Community Benefits Report has been removed. Instead, hospitals will be expected to file community benefits reports at the same time as they file their Form PC with the Division of Public Charities. This change should reduce confusion about filing requirements and also eliminate duplicative paperwork.

We added the recommendation that the draft of the annual Report be circulated before submitting it to the Office of the Attorney General. To this end, the hospital has been asked to solicit and make publicly available any comments generated in response to the Community Benefits Plan (page 10).

The 15 month start-up time envisioned in the Guidelines means that most hospitals will not file their first annual report until sometime after the Spring of 1996 which will coincide with the filing of the annual Form PC. Because of this lengthy delay between the issuance of the Guidelines and the filing of the first annual report, we are asking hospitals to submit a one-time "status report" by February 15, 1995, indicating the status of the hospital's Community Benefits efforts to date and including a copy of the Community Benefits Mission Statement and a description of the Community Benefits planning mechanism. For those hospitals who may find it helpful, an optional form for this status report is attached to the Guidelines.

Thereafter, hospitals may file the annual report at the time of the filing of the Form PC.

Under **Principle F, Section 2 (Measurement)**, we clarified the recommendation that short and long term measurements may actually be quantified in a similar fashion, while retaining the concept that long term measurement means improvement in health status outcomes (page 10).

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As indicated previously, it is our hope that these Guidelines will encourage nonprofit hospitals, in partnership with their communities, to make resource commitments consistent with their individual institutional strengths and with the formally assessed needs of their community. In order to provide assistance to hospitals, particularly smaller community hospitals, in their efforts to accomplish these goals, our Office will offer an educational and training program in the near future.

Thank you again for your valuable contribution to the development of these important Community Benefit Guidelines.

COMMUNITY BENEFITS GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS

TABLE OF CONTENTS

I. INTRODUCTION

A. The Background

Across the nation, nonprofit acute care hospitals -- the linchpin of our current health care system -- are renewing their historic charitable mission. In partnership with the populations they serve, hospitals are directing resources towards providing community-based primary health care to those in need.

Hospitals have been strengthening their community service commitments for many reasons: a growing awareness of the social costs of an inefficient and inequitable health care system; the interest of state officials and contributors of donated funds in encouraging the fulfillment of the charitable obligations of tax-exempt nonprofit hospitals the realignment of institutional priorities as the health care reform agenda unfolds; and the concern of taxpayers, in an era of fiscal austerity, that there be accountability for privileges and benefits bestowed.

Among those privileges and benefits is the exemption from federal, state, and local taxes enjoyed by all charitable corporations, the access to tax-subsidized sources of capital, and the ability to provide tax deductions to their financial supporters. While standards for evaluating the appropriateness of such tax exemptions may vary from state to state, the prevailing trend is to hold nonprofit organizations publicly accountable for providing valued community benefits.

In this Commonwealth—home to the world's most advanced medical knowledge—there are some 600,000 uninsured citizens, and countless more underinsured, who often lack even elementary primary and preventive medical care. While many take hope in the imminence of national or state health care reform, it is clear that for those most in need of affordable care, even universal health insurance will not be a panacea. On the contrary, in the face of heightened pressure for cost containment in a restructured system of health care delivery, some institutions may feel constrained to eliminate services vitally needed by disadvantaged patient populations. It is, therefore, all the more important to create a level playing field now so that the provision of community benefits will become the recognized and accepted charitable obligation of all nonprofit health care providers. To this end, the Attorney General has issued the following voluntary Guidelines with the expectation that each nonprofit hospital in this Commonwealth will make, or continue to make, community benefit programs an integral part of its institutional mission. These Guidelines were developed in order to provide all nonprofit acute care hospitals in the Commonwealth with a working model for the development and implementation of a formal Community Benefits Plan, including focusing the attention of hospitals on meeting the pressing needs of medically unserved or underserved populations.

In seeking to develop Community Benefits Guidelines, the Office of the Attorney General received valuable assistance, comments, and suggestions from numerous health care professionals, providers, and community advocates. In form and substance, these Guidelines have borrowed heavily from the work of the Catholic Health Association of the United States, the Kellogg Foundation, and the Voluntary Hospitals of America. Many nonprofit hospitals in Massachusetts have formally or informally joined such programs and are, therefore, already actively collaborating with their communities to provide fundamental health care benefits to designated populations.

Building on this strong foundation, the Attorney General has developed these comprehensive Community Benefits Guidelines. We welcome further comment as institutions move forward in the adoption and implementation of these Guidelines.

B. Role of the Attorney General

The impact of the problems generated by the health care system are felt virtually everywhere in the Office of the Attorney General. One of the Attorney General's priorities has been to use the law enforcement powers of the office to address a broad range of health care cases and policy issues.

The Regulated Industries Division represents the interests of consumers in advocating lower rates for nongroup and medigap policies. The Antitrust Division applies antitrust laws to hospitals and other providers in mergers and joint ventures. Recently the Office issued the first in the country Guidelines for Hospital Mergers. The Consumer Protection Division prosecutes unfair trade practices in the health care marketplace and strives to enforce relevant disclosure and notice laws. Recently the Division issued the Attorney General's Report on Compliance with Free Health Care Disclosure Laws and issued a pamphlet, with assistance from the Massachusetts Medical Society, on *Choosing a Health Plan? The 10 Most Important Questions You Should Ask!*

The Medicaid Fraud Unit prosecutes those who commit Medicaid Fraud and those who prey on vulnerable consumers with bogus health care or insurance products. The Family and Community Crimes Bureau is involved with and addresses the health care issues raised by the violence, domestic and urban, in our society.

The Office of the Attorney General also has broad statutory oversight responsibilities to ensure that all charitable organizations in the Commonwealth account for their funds and conduct themselves in a manner consistent with their benevolent mission. In order to provide assistance to the stewards of such organizations in the exercise of their fiduciary duties, the Attorney General issued a Guide for Board Members of Charitable Organizations. This Guide has been widely used by institutions such as nonprofit acute care hospitals across the Commonwealth.

Thus, consistent with both the broad oversight and specific statutory responsibilities of the Office of the Attorney General, these Community Benefits Guidelines have been issued. These voluntary Guidelines describe a process by which nonprofit acute care hospitals in Massachusetts might best fulfill their charitable obligations and tax-exempt purpose.

II. SCOPE OF THIS DOCUMENT

This document applies to nonprofit acute care hospitals[1] throughout the Commonwealth (hereinafter referred to as "hospitals"). While municipal hospitals and hospitals which charge no fee for any of their patient care services may find this document helpful in organizing their own community benefit programs, such hospitals are not explicitly covered by these Guidelines.

III. COMMUNITY BENEFITS PRINCIPLES

Hospitals are encouraged to be innovative in developing community benefit programs so as to use institutional strengths and available resources in the most effective way.

These Guidelines offer a flexible framework of the components of a Community Benefits Program and what can be considered a community benefit, as well as a choice of accountability measures. The Attorney General anticipates that these recommendations will facilitate dialogue between the hospitals and the communities they serve:

A. **The governing body of each acute care hospital should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to a formal Community Benefits Plan.**

B. **The Governing Board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan, the method to be followed, the resources to be allocated, and the mechanism for its regular evaluation.**

C. **A hospital should delineate a specific community or communities that will be the focus of its Community Benefits Plan and should involve representatives of that designated community in the planning and implementation process.**

D. **A Community Benefits Plan should include a comprehensive assessment of the health care needs of the identified community as well as a statement of priorities consistent with the hospital's resources.**

E. **The hospital should develop and implement its Plan in a timely fashion.**

F. **Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its level of community benefits expenditures and describes the hospital's approach to establishing such expenditures. The hospital should make the Report available to the public.**

IV. THE GUIDELINES

A. **The governing body of each hospital should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to a formal Community Benefits Plan.**

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[1] Department of Medical Security regulations, 117 CMR 2.02, defines an acute care hospital as "any hospital licensed under M.G.L. Chapter 111, Section 51, and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical, surgical, pediatric, obstetrics and maternity beds as defined by the Department of Public Health." For definition of key terms used throughout these Guidelines, see Glossary on page 13.

In a special Community Benefits Mission Statement, the Governing Board of each hospital should formally affirm its commitment to serve a designated community or patient population. The Mission Statement should explicitly recognize the hospital's traditional partnership with the community, the value of productive collaboration, and the hospital's willingness to allocate resources to address the community's broadly defined health care needs.

It is recommended that this Mission Statement be reviewed and amended by the Governing Board as necessary.

B. **The Governing Board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan, the method to be followed, the resources to be allocated, and the mechanism for regular evaluation.**

Crucial to the effectiveness of a Community Benefits Plan is the active participation, of the hospital's Governing Board and senior management. While the Governing Board should place responsibility for the Plan's implementation at the highest organizational level, it is equally important that the hospital create a shared sense of purpose and commitment among all members of the hospital staff.

For example, the hospital could designate an individual or group, under the direction of a senior level manager, responsible for planning, organizing and evaluating the hospital's Community Benefits program. That planning group would be an integral part of the general policy development and budgeting process of the hospital and would be accountable directly to the Governing Board.

Regular evaluations of the Plan and its implementation should be reviewed by the Governing Board. Where necessary, appropriate amendments to the Plan should be made by the Board.

Copies of the Plan should be provided to all those involved in its development and should be made widely available for comment. Following the comment phase, the Governing Board should formally review, revise, and adopt the Community Benefits Plan.

C. **A hospital should delineate a specific community or communities that will be the focus of its Community Benefits Plan and should involve representatives of that designated community in the planning and implementation process.**

In order to form a bridge to community leaders and representatives of the medically underserved, hospitals should establish a Community Benefits Advisory Group, or other similar mechanism, which includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community.

1. Defining Community

The first step which a hospital should take in formulating a Community Benefits Plan is to define its relevant community for those purposes, a definition which may differ from that used for its patient care population. The step should be accomplished in collaboration with the community in which the hospital is located and, if different, the community which the hospital historically has served.

Hospitals are encouraged to be creative in defining their community, so long as there is a definition that is clear and for which outcomes can be measured.

It is possible that more than one community may be chosen as the focus of a hospital's Community Benefits Plan. For some hospitals located in the same geographic area, it may be desirable to collaborate with each other in order to establish each hospital's "community" and to develop a coordinated plan.

The following are some examples of how a community may be defined:

a. The geographic boundary approach, e.g. a city, town, or county, or several contiguous municipalities;

b. The demographic approach, e.g. a community may be defined by (i) the low or moderate income persons who are uninsured or underinsured; (ii) the elderly; or (iii) pregnant women of low or moderate income;

c. The outreach approach would involve a hospital's reaching beyond the geographic boundaries of its service area in order to apply its community benefits resources to undeserved populations and neighborhoods elsewhere as long as the community parameters are drawn to permit ease of access to the hospital or to its mobile facilities;

d. The health status approach focusing on the prevalence of a particular disease, such as HIV, STD, diabetes, cardio-vascular. This approach may involve contiguous neighborhoods, municipalities or whole counties.

2. Community Process and Input

The goal is to identify the health care needs, especially the needs of unserved and undeserved populations, within the designated community through a process as open and inclusive as possible. Hospitals should consider community representatives as full partners in the process of identifying health care needs.

Whenever feasible, information should be collected directly from the population at risk and from those organizations and social service providers which are closest to the designated populations, such as: health care providers, community health centers, neighborhood associations and community organizations, local boards of health, local health planning networks, community action agencies, private charitable organizations, schools, churches and clergy, police, housing authorities, and ambulance services.

In addition, the hospital is encouraged to initiate a formal process, such as an annual public hearing, to solicit the views of community members. At such public events, the hospital might wish to invite the participation of local and state public health departments or other public and private agencies that provide information or that coordinate resources to achieve public health objectives.

D. **A Community Benefits Plan should include a comprehensive assessment of the health care needs of the identified community as well as a statement of priorities consistent with the hospital's resources.**

1. Developing the Plan

In developing its Community Benefits Plan, the hospital, in partnership with its community, should consider carrying out the following steps:

a. Assess community needs, taking into account all data and information already available, and avoiding duplication wherever possible;

b. Establish a set of priorities of community health care needs that are the primary candidates for the resources of a Community Benefits Plan;

c. Prepare an inventory of all the community service and community benefit programs currently provided by the hospital, as well as by other health care providers, or social service agencies, that correspond to identified community health care needs. For purposes of reporting and quantification, health care programs can be broadly defined, and essential community service programs already in existence can be incorporated into the hospital's Community Benefit Plan, so long as that Plan is the result of a hospital-community dialogue;

d. Re-examine existing community benefit commitments and priorities in light of formally identified community needs and hospital resources;

e. Identify short-term (one year) and long-term (three to five year) goals, described with as much specificity as possible;

f. Determine the need for additional resources such as paid and volunteer staff, as well as for additional physical facilities, mobile health units, and other resources;

g. Using the priorities established in item 2, as well as the information developed in items 3, 4, 5, and 6, prepare a budget for the Community Benefits Plan, indicating expenses, expected revenues and outside sources of funding;

h. Determine time frames for implementing each aspect of the Plan;

i. Take a leadership role in coordinating community benefit projects, taking into account existing community-based programs that may already be providing important health-related services;

j. Encourage hospital-wide and community-wide involvement in the planning and implementation of the Community Benefits program;

k. Retain the flexibility to respond to unanticipated emergencies and continue to respond rapidly to provide appropriate aid in critical time of need.

2. The Needs Assessment Process

The needs assessment should be based on public health data and other health status indicators, as well as consultations with representatives of the designated community. Efforts should be made to make use of existing data and information and to avoid "reinventing the wheel" by duplicating

information that is already available. In order to avoid wasteful duplication when assessing needs, hospitals should begin by looking at existing health status information already collected by public and private entities, most particularly the Department of Public Health, the Department of Mental Health, and the Rate Setting Commission.

In deciding which benefits to provide, the hospital should take into account the health care problems of medically undeserved and disadvantaged populations, and should aim to reduce racial and ethnic disparities in health status. While the hospital should take cognizance of special health-related problems in a particular community, even if such problems may not be unique to the disadvantaged, priority should be accorded to the health care needs of disadvantaged and vulnerable populations within the hospital's designated community.

There are several different approaches to conducting a needs assessment. At a minimum, the hospital's needs assessment process should involve members of the staff who are most knowledgeable about the needs and available resources in the community. Invited members from outside the hospital should include community leaders, representatives from the other health care and service providers, and members of the population(s) at risk. The Community Benefits Plan should focus on projects that enhance the health status of the designated community.

Attention should be given to the special needs of the poor, of the elderly, of racial, linguistic, and ethnic minorities, and of refugees and immigrants. It is recommended that, where appropriate, hospitals establish interpreter services so that linguistic differences do not present a barrier to accessible health care.

Data compiled from all sources should be evaluated, with areas of need ranked in order of priority, using at least the following criteria: (1) income level of the affected population; (2) presence of significant barriers that hinder access to appropriate health care delivery programs; (3) absence of relevant and accessible resources and programs; (4) specific primary, acute, or chronic health care needs; (5) assessment of the hospital's capability of responding to the identified needs; (6) availability of other service providers, both public and private.

A comprehensive needs assessment of the defined population should be considered at least every three years.

E. The hospital should develop and implement its Plan in a timely fashion.

The development and implementation of a hospital's Community Benefits Plan will necessarily occur in phases.

The following sequence is offered as a suggestion for those hospitals who wish to complete this process within the next 15 months.

Phase 1 - Adoption by the Governing Board of the Community Benefits Mission Statement should occur within three months of the issuance of these Guidelines.

Phase 2- Formation of the hospital's Community Benefits planning mechanism for developing the operational Plan should occur within four months following the issuance of these Guidelines.

Phase 3 - Community Benefits Needs Assessment should be completed within nine months of the issuance of these Guidelines.

Phase 4- The development and adoption of the Community Benefits Plan should be completed within fifteen months of the issuance of these Guidelines.

Phase 5- The implementation of the Community Benefits Plan should begin within fifteen months from the issuance of these Guidelines.

Phase 6- The Community Benefits Plan and its results should be reviewed at least annually.

F. Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its level of community benefits expenditures and describes the hospital's approach to establishing such expenditures. The hospital should make the Report available to the public.

1. Annual Report

The hospital should file with the Attorney General's Division of Public Charities an annual report on its Community Benefits Plan. The first report should be submitted by February 15, 1995, indicating the status of the hospital's Community Benefits effort to date and including a copy of its Community Benefits Mission Statement and a description of the hospital's Community Benefits planning mechanism. An optional form for such report is attached for those hospitals who may find it to be helpful. Thereafter, the annual report should be filed at the time the hospital files its Form PC. Beginning with the second report, the annual Community Benefits Report should include, but not be limited to, the following components:

a. The Community Benefits Mission Statement;

b. A copy of the current version of the Community Benefits Plan;

c. Delineation of the hospital's community for the purposes of its Community Benefits Plan;

d. Identification of the community health care needs that were considered in developing and implementing the Community Benefits Plan;

e. The mechanism by which views were solicited from the hospital's community, including organizations and people with whom the hospital met and worked;

f. The short (one year) and long-term (three to five year) goals of the Community Benefits Plan, described with as much specificity as practicable;

g. A narrative description of the types of gross community benefits and community services actually provided or, if applicable, to be provided. This description can include measurements related to number of patients or health status outcomes as explained in section F.2 below;

h. In accordance with the Community Benefits Plan, disclosure of the value of gross and net community benefits, calculated consistent with the Glossary section of these Guidelines, and displayed relative to the hospital's audited total patient operating

expenses. If not already stated in the Plan, the hospital should indicate the about of value, or the percentage of the total value, attributable to each type of benefits provided or to be provided.

The hospital may decide to circulate a draft of its annual Report and Community Benefits Plan before submitting that Report and Plan to the Office of the Attorney General.

Community response to the Community Benefits Plan or Report is encouraged and should also reflect the positive aspects of the Plan and/or Report. Hospitals are encouraged to solicit and make publicly available comments generated in response to the Community Benefits Plan.

In the event that a community, community group or an individual disagrees with a hospital's choice of a Community Benefits Plan, or disagrees with any material aspect of the program or process used to create a Community Benefits Plan, said community, community group or individual shall have the right to file a separate report, and the report will be made a public record on file at the Division of Public Charities.

At the end of each reporting cycle, the Attorney General intends to make public a record of the extent of Massachusetts hospitals' participation in the process outlined in these Guidelines.

2. Options for Measurable Objectives and Outcomes

The long term measure of the success of a Community Benefits Plan should be the improvement in health status outcomes of the hospital's defined community. Both short and long term measurements could be quantified in the following ways:

(a) The number of patients treated in a particular area for a given condition, i.e. number of immunizations, number of pregnant teenagers served, number of adolescents tested and counseled for AIDS;

(b) The reduction or improvement in a particular health status indicator, i.e. the reduction in incidence of tuberculosis, the reduction in teen pregnancies, the reduction in numbers of adolescents with AIDS.

Community health status outcomes can be determined by consulting the Health Status Indicators of the Department of Public health and the data on Preventable Hospitalizations in Massachusetts proposed by the Rate Setting Commission.

3. Establishing the Level of Community Benefits Expenditures

Hospitals are encouraged to establish a Community Benefits budget and to make a good faith effort to measure expenditures and administrative costs associated with the process. Recognizing that some community benefits are not subject to a good faith estimate of value, the Attorney General asks hospitals that provide benefits not easily quantified to report a full and accurate description of such benefits.

These Guidelines encourage hospitals to adopt the approach set forth below in determining the level of gross community benefits expenditures. This flexible approach reflects the fact that hospitals vary greatly in size, structure and available resources.

In collaboration with its community, the hospital could identify a reasonable amount of gross community benefits to be provided by taking various financial indicators, including the following factors, into consideration:

(i) The total unreimbursed cost to the hospital of providing health care services in accordance with the Massachusetts free care pool, M.G.L. c. 6B §1.

(ii) Audited total patient operating expenses and audited total operating revenues;

(iii) Accumulated operating surpluses or deficits; compensation structures and levels relative to industry norms;

(iv) The net value of the hospital's tax exempt benefits, if that figure is available.

Hospitals should be aware that the successful implementation of this approach is directly related to the quality of the collaboration with the community that takes place. It is incumbent upon hospitals choosing this approach to consult actively and openly with and cooperate with community groups and representatives in establishing a reasonable expenditure level.

The Attorney General considered recommending a second approach as an alternative. However, in order to provide hospitals an opportunity to implement their commitment to work collaboratively and systematically with their communities to meet health needs and improve community health status, the Attorney General is deferring recommendation of this approach for the first two years following the issuance of these Guidelines. This second, presently deferred, approach would be linked to the size of the institution in order to take into account the resource opportunities of hospitals of all sizes, from small community institutions to large urban medical centers. In this deferred approach the target goal for gross community benefits would be accomplished consistent with the financial values associated with achieving the various health care priorities chosen for the Community Benefits Plan as discussed in Section D and E of this document. Once priorities had been chosen, values could be attached and additional priorities could be included as may be necessary to reach a particular target level of gross community benefits expenditure. The target goals that would be envisioned in this approach are:

a) For hospitals with audited total patient operating expenses under $200 million, up to 3% of such expenses (although there would be significant flexibility within this alternative, target levels at the lower part of this range would be anticipated only for hospitals whose financial circumstances warrant such a target level).

b) For hospitals with audited total patient operating expenses over $200 million, 3% to 6% of such expenses.

After information regarding Community Benefits expenditures has been reported for the first two years following the issuance of these Guidelines, the Attorney General will review the data, and, in consultation with health care providers and community advocates, recommend appropriate adjustments if any, in the recommended approach (es).

V. CONCLUSION

These Guidelines embody the recommendations of the Attorney General in key areas of process and substance. They have been developed in order to provide the Governing Board and senior management of nonprofit acute care hospitals with helpful assistance in the fulfillment of their charitable purpose. The current changes in health care delivery carry a clear challenge to Massachusetts hospitals and to their communities. In the face of increasing competition and economic pressure to curtail unnecessary health care costs, extra vigilance is required to ensure that the needs of vulnerable and at-risk populations are not neglected.

With institutional change on the horizon and already underway, the Attorney General anticipates continued evolution and refinement of the process outlined in these Guidelines and welcomes constructive suggestions from all sources.

VI. GLOSSARY

"**Hospital**" means nonprofit acute care hospitals.

"**Actual costs**" means all direct and indirect costs incurred by a hospital in providing health care and health-care related services to its patients, determined in accordance with generally accepted accounting principles.

"**Acute Care Hospital**" means a hospital licensed under section fifty-one of M.G.L. Chapter 111 and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

"**Net charity care**" means the actual costs—and not the hospital charge—of providing "free care" to patients, in accordance with the definition of "free care" in M.G.L. Chapter 6B §1, and excluding reimbursement by state or federal government or payments from the Massachusetts uncompensated free care pool. Net charity care excludes services paid for or reimbursed by federal and state governments for health care sponsored programs, including Medicaid and Medicare services, and also excludes any "shortfall" in revenue incurred by a hospital for such services. Those amounts excluded from net charity care are also to be excluded from "Gross community benefits".

"**Gross community benefits**" means the actual costs to a hospital of providing net charity care and/ or broadly defined health care related community benefits and services in accordance with a hospital's Community Benefits Plan. Gross community benefits excludes services paid for or reimbursed by federal and state governments for health care sponsored programs, including Medicaid and Medicare services, and also excludes any "shortfall" in revenue incurred by a hospital for such services.

Community benefits which the hospital is already providing are included within this definition so long as such on-going programs and services are consistent with, and become a part of, the Community Benefits Plan.

Community benefits projects may include, but certainly are not limited to:

- The cost of unreimbursed free care, in accordance with the definition of "net charity care" as defined herein;

- Community health education through informational programs, publications and outreach activities in response to a formally adopted Community Benefits Plan;

- Free preventive care or health screening services;

- Mobile health vans;

- Home care consistent with the definition of net charity care;

- Medical and clinical education and research conducted in response to a previously assessed community need where such need and the education and research are specifically parts of the Community Benefits Plan;

- Support for and participation in community oriented training programs;

- Low or negative-margin services which are offered in response to an identified community need. Such services include immunization programs, services to persons with AIDS, psychiatric care for deinstitutionalized and homeless persons, and outpatient mental health services for vulnerable populations;

- Violence-reduction education, counseling, and other related measures;

- Anti-smoking education and related activities;

- Substance abuse education and related preventive and acute treatment services;

- Domestic violence reduction education and training services;

- Early childhood wellness programs;

- Expanded prescription drug programs;

- Volunteer services (if part of the community benefit Plan);

- Net financial assistance to independently licensed and hospital licensed community health centers and community mental health centers;

- Unfunded services that are ancillary to Medicaid or Medicare service, if part of a community benefits program, such as certain kinds of personal care/home care services for which Medicaid or Medicare does not provide any reimbursement.

The common denominator among all community benefits is that they be part of a Community Benefits Plan that responds to a specific health care need identified through a formal assessment process with the active collaboration of the population to be served. Donations, grants, fees and charges and/or any revenue received as a result of community benefits conferred should also be reported on the hospital's annual Community Benefits Report to be filed with the Office of the Attorney General.

"**Net community benefits**" means "Gross community benefits" minus any donations, grant, fees, and charges or other revenue generated as a result of the provision of such services.